ATTACHMENT 1

NATIONAL HCFA 1500 CLAIM FORM SAMPLE

PICA — **HEALTH INSURANCE CLAIM FORM** — PICA

CARRIER

PATIENT AND INSURED INFORMATION

1 MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER (Medicare #) D (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)		1a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A	3 PATIENT'S BIRTH DATE MM DD YY SEX MM DD YY M X F	4 INSURED'S NAME (Last Name, First Name, Middle Initial)
5 PATIENT'S ADDRESS (No., Street) 609 Willow St	6 PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7 INSURED'S ADDRESS (No., Street)
CITY: Anytown — STATE: WI	8 PATIENT STATUS Single Married Other	CITY — STATE
ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX) XXX-XXXX	Employed Full-Time Student Part-Time Student	ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P	10 IS PATIENT'S CONDITION RELATED TO	11 INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a INSURED'S DATE OF BIRTH MM DD YY SEX M F
b OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b AUTO ACCIDENT? PLACE (State) YES NO	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — MM DD YY TO
17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE I.M. Prescribing	17a. I.D. NUMBER OF REFERRING PHYSICIAN 12345678	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — MM DD YY TO
19 RESERVED FOR LOCAL USE		20 OUTSIDE LAB? $ CHARGES YES NO
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1 V539.__ 3 ____.__ 2 ____.__ 4 ____.__		22 MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO. 23 PRIOR AUTHORIZATION NUMBER 1234567

24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 14 92	4	P	W6808	11	1	XXXX XX	1				
2 02 14 92	4	P	W6808	12	1	XXX XX	1				
3 02 14 92	4	P	W6808	13	1	XXX XX	1				
4 02 14 92	4	P	W6808	14	1	XX XX	1				
5 02 14 92	4	P	W6808	15	1	XX XX	1				
6											

25 FEDERAL TAX I.D. NUMBER SSN EIN	26 PATIENT'S ACCOUNT NO. 1234JED	27 ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28 TOTAL CHARGE $ XXXX XX
29 AMOUNT PAID $ XXX XX	30 BALANCE DUE $ XXXX XX		

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
I.M. Authorized
MM/DD/YY
SIGNED DATE

32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M. Billing
1 W. Williams
Anytown, WI 55555
PIN# GRP# 87654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8 86)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (U2) (12-90)
FORM OWCP-1500 FORM RRB-1500